

National Dementia Action Plan 2024-2034

Annual Activity Reporting

First Report (2025) - Queensland



Introduction

The [National Dementia Action Plan 2024-2034](#) (Action Plan) provides a comprehensive framework for dementia policy across Australia. The Action Plan outlines a strategic approach to improving the lives and care of people living with dementia, ensuring coordinated efforts across all levels of government.

Annual activity reporting provides information about how jurisdictions are implementing the Action Plan. This first report provides an outline of activity underway aligned to the agreed national priority actions for the first 3 years. The Collective Priority Framework identifies these as:

- Action 3: Empower individuals and communities to minimise risk where they can, and delay onset and progression
- Action 4: Improve dementia diagnosis and post-diagnostic care and support
- Action 8: Improve dementia data, maximise the impact of dementia research and promote innovation.

Sub-actions are included for the priority actions in each report to reflect relevance to work underway. Reported activity may contribute wholly or in part to these sub-actions. Some activities may span more than one high-level action.

Annual reports also provide an opportunity to share information on activities underway for any actions in the Action Plan.

Future reports will provide updates on work in progress, new dementia-related initiatives or changes to existing policies and programs.

The Australian Institute of Health and Welfare (AIHW) will report on key progress indicators to show how the Action Plan is making a difference to improve outcomes for people living with dementia. This will be publicly tracked and reported through the [National Dementia Action Plan indicators dashboard](#) on the AIHW website.

Activity reporting templates for national priority actions

ACTIVITY REPORTING – Queensland	
<p>Action 3 – Empower individuals and communities to minimise risk where they can, and delay onset and progression.</p> <p><u>Relevant sub actions</u></p> <p>3.1 - Improve Australians’ awareness of risk factors and preventive actions that can be taken to reduce the risk of developing, delay the onset or slow the progression of dementia. This includes health promotion and prevention programs which support overall health.</p> <p>3.2 - Promote the brain health benefits of people regularly and safely participating in sports, exercise and movement.</p> <p>3.5 Implement evidence-based interventions to reduce the risk of dementia, including for higher risk populations and people with mild cognitive impairment (MCI).</p>	
Rationale for sub-action focus areas	<p>Queensland Health recognises the importance of dementia prevention and risk reduction initiatives. Undertaking these activities and programs help Queenslanders reduce their risk of developing dementia, delay the onset of dementia, and slow the progression of dementia.</p>
Work underway	<p>Queensland Health is delivering a range of programs and initiatives that aim to reduce dementia risk, delay cognitive decline and support healthy ageing by addressing modifiable risk factors, promoting independence, and embedding prevention and early intervention across community and hospital settings.</p> <p>Key examples include:</p> <ul style="list-style-type: none"> <p>EAT WALK ENGAGE – A multidisciplinary program that aims to improve care for older people in hospital, prevent delirium and promote faster recovery. The program supports hospitals to be older-person friendly through engaging older consumers and carers, improving team communication, empowering local leadership, supporting education and training, and advocating for environmental redesign. The program focuses on improving the mobility, cognitive engagement and nutrition of patients to reduce the likelihood of patients developing delirium, a condition known to increase the risk of developing dementia or worsening existing dementia.</p>

	<ul style="list-style-type: none"> • The Older Persons Enablement and Rehabilitation for Complex Health Conditions (OPEN ARCH) - A multidisciplinary Gerontology program delivered in Primary Care and co-located with General Practitioners clinics, that provides enhanced early identification and coordinated care for older people with complex care needs who are at risk of functional decline or hospitalisation. • Geriatric Evaluation and Management and Geriatric Evaluation and Management Rehabilitation – Hospital in the Home (GEM/GEMR-HITH) – A hospital equivalent sub-acute geriatric and rehabilitation care program for older patients in their home, which supports people living with dementia to maintain independence and avoid hospital related decline. • Queensland Dementia, Ageing and Frailty Clinical Network (QDAF) – A network that includes health professionals, consumers and key stakeholders across Queensland who are dedicated to improving dementia, ageing and frailty services. The QDAF Steering Committee sets the direction of the network. QDAF provides statewide clinical leadership, collaboration and expert advice to support better care for older people, including supporting prevention and early intervention activities through initiatives such as workforce capability building. • Seniors Social Isolation Program – A range of programs designed to reduce loneliness and foster social connections, which can have a significant impact on combating dementia as social engagement and mental stimulation are critical factors in maintaining cognitive health as people age. Social isolation services offer information and advice to older people and can connect them to local services which provide a broad range of activities tailored to local need, including activities such as tai chi, dancing and craft to excursions and group activities.
<p>Achievements and insights</p>	<p>The following achievements and insights have been realised:</p> <ul style="list-style-type: none"> • Since 2019, the EAT WALK ENGAGE program has been implemented across 52 wards in 18 Queensland Health hospitals, improving patient outcomes in these settings. In 2025, the program reached over 4,000 older Australians in hospital to prevent delirium and other complications. The implementation of the program demonstrated that delirium prevention at scale was achievable and delivered clinical, patient experience and system benefits when supported by strong implementation infrastructure and leadership. • In 2025, the GEM/GEMR-HITH was delivered across 11 Hospital and Health Services and included 13 Queensland Health hospitals with high reported patient satisfaction. Effective delivery of models such as GEM/GEMR-HITH requires investment in education and capacity building to support the success and sustainability of services. • OPEN ARCH successfully expanded into an outreach model to local and regional Aboriginal and Community Controlled Health Organisations, which increased participation and attendance by First Nations patients at their location of choice. Links between hospital, primary care and the community were strengthened, reducing duplication of investigations and providing real time feedback to primary care teams.

	<ul style="list-style-type: none"> • Through the QDAF Steering Committee, statewide clinical guidance, tools and pathways were developed and disseminated, supporting earlier intervention, consistent care and improved clinical decision making across Queensland’s care settings. Strong clinical networks, including QDAF and other alliances, support statewide prevention strategies and clinicians by enabling coordination, consistency, and scaling of evidence-based approaches across Hospital and Health Services. • In 2025, the Seniors Social Isolation Program included 66 social isolation services across the State. From 1 January 2025 to 31 December 2025, social isolation services provided 72,037 service hours to 157,853 older people. Older Queenslanders who accessed these services said that they felt better informed, learned new skills and continued to access services because they enjoyed interacting with friends and they felt welcome and valued. Supports in a local community contribute to building age-friendly communities and strengthen personal and community connection. Strong social connection can help lower the risk of dementia and provide a range of health benefits as people age.
<p>Strategic collaboration and partnerships</p>	<ul style="list-style-type: none"> • QDAF Clinical Network strengthened cross sector collaboration by bringing together clinicians, consumers and stakeholders, enabling shared learning, co-design and the spread of evidence-based models of care across Queensland. The QDAF Clinical Network hosted meetings and forums to discuss key topics including prevention-focussed initiatives.

ACTIVITY REPORTING – Queensland

Action 4 – Improve dementia diagnosis and post-diagnostic care and support.

Relevant sub actions:

4.3 Clarify pathways for dementia screening, assessment and diagnosis across the country, including identification of best practice

4.7 Improve support, care coordination and planning for people living with dementia and their carers following diagnosis, including models for First Nations, CALD and other diverse communities.

<p>Rationale for sub-action focus areas</p>	<p>Queenslanders living with dementia or a cognitive impairment are at an increased risk of adverse outcomes in hospital. These adverse outcomes include delirium, functional decline and extended lengths of stay. The strengthening of pathways for the early identification, assessment and management of cognitive impairment, alongside improved care planning and coordination following diagnosis, supports the delivery of consistent and person-centred care.</p>
<p>Work underway</p>	<p>Queensland Health implemented several initiatives to support the identification and management of cognitive impairment and to improve care planning for Queenslanders living with dementia.</p> <p>Key examples include:</p> <ul style="list-style-type: none"> • Acute Cognitive Care Units – Provide a safe, suitable clinical environment to reduce the severity of behavioural and psychological symptoms in patients living with dementia. The multidisciplinary team partners with patients and their families/carers/significant others to achieve optimal wellbeing and quality of life through the delivery of specialised interventions that address physical, psychological, social and spiritual needs. • Practical Redesign Options for Violence in Dementia and Delirium (PROVIDE) Project – A project that aims to develop a best practice approach to improve care quality for people with dementia and/or delirium who exhibit aggressive or violent behaviours and reduce the escalation of behaviours. • Aboriginal and Torres Strait Islander Healthy Ageing Clinic (The Healthy Ageing Clinic) –A pilot initiative delivered throughout 2025, providing specialist geriatrician services in a culturally safe environment for Aboriginal and Torres Strait Islander people aged over 50 years presenting with chronic/complex conditions relating to ageing, frailty, disability and cognitive decline (i.e. dementia diagnosis and management). • Neurological Healthcare Initiatives - The Queensland Government is committing \$10.45 million to deliver a range of initiatives supporting people with neurological conditions, including dementia. This includes the establishment of eight

	<p>Neuro Wellness Hubs and a statewide neurological e-gateway. Implementation of these commitments has commenced.</p> <ul style="list-style-type: none"> ○ Neuro Wellness Hubs - Procurement for the Hubs will begin mid-2026, with delivery scheduled for 2027. ○ Neurological e-gateway - In late 2025, Queensland Health launched the statewide neurological e-gateway as a centralised access point to information on services and supports for Queenslanders with neurological conditions. It is designed to connect users with supports, community organisations and national programs such as Dementia Australia. Queensland has partnered with non-government organisations to support the provision of accurate information on available supports through the gateway. The gateway aims to improve system navigation and access to care for people living with complex neurological conditions, including dementia, as well as their families and carers. Implementation is being supported by communications to increase awareness of the e-gateway. <ul style="list-style-type: none"> ● Dementia Focused Communications Plan – In late 2025, Queensland Health commenced developing a communications plan focussed on supporting clinicians, with implementation anticipated to commence in 2026. The plan aims to: <ul style="list-style-type: none"> ○ Strengthen clinician awareness, understanding and capability in dementia best practice care, including prevention-focussed conversations and the provision of dementia-inclusive care to both patients and carers. ○ Provide clinicians with the knowledge needed to promote dementia-friendly environments within healthcare settings. ○ Foster collaboration and consistency across the system through the alignment of communication efforts. ● Specialist Dementia Care Program (SDCP) – The SDCP is a Commonwealth funded program providing short term, specialist residential care for people with severe behavioural and psychological symptoms of dementia who cannot be supported in mainstream aged care. Although the program is Commonwealth funded, Queensland Health’s Hospital and Health Services deliver the specialist clinical in-reach services to support Specialist Dementia Care Units across the state. These services provide specialist clinical assessment, management and escalation support for participants, and are important to the safe and effective delivery of the program.
<p>Achievements and insights</p>	<p>The following achievements and insights have been realised:</p> <ul style="list-style-type: none"> ● In 2025, new Acute Cognitive Units opened in Logan Hospital and Gold Coast University Hospital. The unit at the Gold Coast University Hospital is part of a 70-bed expansion, which also included two Geriatric Evaluation and Management units and a Complex Care unit. More than 1,600 staff received dementia care training ahead of the facility opening. ● In 2025, the PROVIDE Project successfully completed a statewide review and report of Queensland Health hospitals’ clinical practices, environmental designs, workforce capability and education. The project delivered a hospital wide model of care framework and redesign toolkit, developed to assist Queensland hospitals to improve care for patients with dementia and/or delirium experiencing aggressive behavioural symptoms. The project identified the importance of access to expert

	<p>clinicians, dementia-enabling infrastructure and dementia and delirium specific clinical skills and training.</p> <ul style="list-style-type: none"> Initial findings of The Healthy Ageing Clinic highlighted that the service met patient needs and provided access to a range of specialist geriatric services for older people in a culturally safe environment, with clients, carers and staff reporting positive experiences. Providing opportunities to enhance knowledge and skill sharing between service providers was also identified as a key outcome. Options that could be explored to enhance service delivery include the use of telehealth options/home visits to increase reach and meet client needs/preferences and recruitment of an Aboriginal and Torres Strait Islander Healthcare Worker to support access, engagement and navigation with related services. The delivery of the Neurological e-gateway has highlighted system navigation as a core component of the provision of good care for those living with dementia and their families. Digital platforms play a key role in improving equity of access to information, especially for Queenslanders living in regional and remote areas. The delivery of the SDCP in Queensland has strengthened collaboration between the health and aged care systems, increasing coordinated care for people living with dementia with severe behavioural and psychological symptoms. Effective delivery of the program relies on strong state level coordination, underpinned by Commonwealth funding. The program highlighted the importance of specialist dementia care within broader dementia care pathways, particularly in supporting appropriate and safe transitions of people living with dementia who experience severe behavioural and psychological symptoms.
<p>Strategic collaboration and partnerships</p>	<ul style="list-style-type: none"> The Healthy Ageing Clinic is a pilot initiative between Metro North Health, Moreton Aboriginal and Torres Strait Islander Community Health Service, and the Institute of Urban Indigenous Health.

ACTIVITY REPORTING – Queensland	
<p>Action 8 – Improve dementia data, maximise the impact of dementia research and promote innovation.</p> <p><u>Relevant sub actions:</u></p> <p>8.1 Encourage investment in research, innovation and research translation on prevention, risk reduction, diagnosis, treatments (including a cure), holistic care and management for all types of dementia</p> <p>8.3 Improve understanding of outcomes for people living with dementia from First Nations, CALD and other diverse communities</p> <p>8.5 Improve health, social and aged care data collection, accessibility and integration to support research, inform policy and service planning, monitor improvements and reporting on outcomes for all types of dementia.</p>	
Rationale for sub-action focus areas	<p>Queensland Health recognises that strengthening data, research and innovation enables evidence-based planning, service improvement and monitoring of dementia related outcomes. Improving data collection, co-design, research translation and fostering innovation will help ensure that the initiatives are effective and responsive to the needs of people living with dementia.</p>
Work underway	<p>Queensland Health has implemented initiatives that support research and data collection to inform health service delivery, policy and service planning activities to improve care for Queenslanders living with dementia.</p> <p>Key examples include:</p> <ul style="list-style-type: none"> • The Queensland Health Clinical Research Fellowships Program – Established in 2018, the program aims to support clinician led, practice embedded research that improves healthcare delivery and patient outcomes. In 2023, the program was expanded to include the Targeted Research Fellowships program. By funding frontline clinicians to investigate priority health challenges, the program generates applied evidence and service innovation which, while not always dementia specific, contributes to improved understanding, prevention and care of people living with dementia across the health system. • Queensland Health Delayed Discharge Data Collection - Queensland Health collates and reports data for patients experiencing delayed discharge to assist in efficient resource allocation and improved patient care. People experiencing delayed discharge are inpatients that are clinically ready for discharge but are awaiting appropriate supports to transition to the community, including people living with dementia. Measuring the volume of patients experiencing delayed discharge, including delays relating to the availability of dementia supports, enables hospitals to tailor care plans and facilitate timely transitions to appropriate community care settings to optimise patient outcomes.

	<ul style="list-style-type: none"> • Market research on supporting Queenslanders to plan for older age – An initiative aimed at developing insights to inform potential new initiatives to support: <ul style="list-style-type: none"> ○ Older Queenslanders and the broader community to proactively plan for later life and act early to support good health in old age. ○ Carers and family members to have conversations with the older people in their lives around planning for care.
<p>Achievements and insights</p>	<p>The following achievements and insights have been realised:</p> <ul style="list-style-type: none"> • Since inception, Queensland Health Clinical Research Fellowship Program has awarded \$18.7 million to 98 Fellows with a strong emphasis on translating research into real world clinical practice and building system wide research capacity. Under the expanded Targeted Research Fellowships program, Fellowships worth \$2.93 million have been awarded to 26 Fellows. Funded studies are linked to improving broader health outcomes and care, with the potential to be transferable to delirium and dementia behavioural symptom management and care in hospital settings. For example, several studies focused on behavioural risk, multimorbidity, diagnostic innovation and care model redesign. These studies continue to support evidence generation directly relevant to dementia prevention, progression and care. • Queensland Health Delayed Discharge Data Collection informed the development of system level policy responses to delayed discharge by providing a solid evidence base to guide coordinated action, optimise resources and improve outcomes for older patients, including people living with dementia.
<p>Strategic collaboration and partnerships</p>	<ul style="list-style-type: none"> • A key objective of the Queensland Health Clinical Research Fellowships Program is to build collaborative linkages between Queensland Health and the wider Queensland health and medical research sector.

Other activities underway

Governments undertake activities across the breadth of the Action Plan. The table below provides an opportunity to showcase any activities that support the Action Plan's broader actions, in addition to the identified priority actions.

ACTIVITY REPORTING – Queensland		
OTHER ACTIVITIES UNDERWAY		
NDAP Action(s)/sub-action(s)	Activity	Achievements and Insights
<p>Action 5 - Improve treatment, coordination and support for people living with dementia</p> <p>Sub Action 7 - Identify the needs of people living with dementia at entry to hospital. Have supports, structures and care in place to reduce the potential risk of harm, provide a person-centred approach to care and ensure safe and effective transitions into and from hospital services.</p>	<p>Internal Aged Care Placement Assistant – In September 2025, a 6-month pilot commenced in a staged approach. The pilot is being delivered in 3 Hospital and Health Services.</p> <p>The pilot aims to reduce delays for patients that are clinically ready for discharge by providing temporary funding for aged care placement assistants, to support clinicians coordinating Residential Aged Care Placements or discharge to community.</p>	<p>Hospital and Health Services have developed integrated and streamlined aged care pathways with the allocation of dedicated resources.</p>
<p>Action 5 - Improve treatment, coordination and support for people living with dementia</p>	<p>Long-Stay Rapid Response and Preventing Avoidable Presentations of Older People – An internal pathway for Hospital and Health Services to support individual solutions for patients to discharge from or avoid hospital.</p>	<p>The program enables hospital avoidance or discharge by addressing systemic gaps and delays in mainstream systems through interim, time-limited solutions.</p> <p>As of 3 February 2026, the program has supported 522 older patients to discharge or avoid hospital,</p>

<p>Sub Action 7 - Identify the needs of people living with dementia at entry to hospital. Have supports, structures and care in place to reduce the potential risk of harm, provide a person-centred approach to care and ensure safe and effective transitions into and from hospital services.</p>	<p>The program funds interim solutions for patients, including (and not limited to): interim care, assistive technology, nursing supports and interim accommodation.</p>	<p>reducing the cohort’s collective length of stay by 34,564 bed days.</p> <p>The program has highlighted significant gaps in transition supports to residential aged care, especially for persons who require specialised or slower transitions into care.</p>
<p>Action 5 - Improve treatment, coordination and support for people living with dementia</p> <p>Sub Action 3- Enable best dementia care practice in aged care and disability support services, focused on enhancing the quality of life, wellbeing and safety of people living with dementia and that meets their social and cultural preferences.</p>	<p>Julian’s Key Health Passport - A consumer-controlled, communication tool to improve care of people with disability whilst in hospital. The tool was co-designed with Queensland disability community members.</p> <p>It captures important consumer-driven information and is available in hardcopy or as a downloadable, editable PDF (translated into several languages). Supporting resources have been developed including consumer and staff guides and factsheets.</p>	<p>Following 18 months of targeted consultation, an updated version of Julian’s Key was launched in November 2024. Early anecdotal evidence suggests benefits for people in aged care settings and for people living with dementia and/or delirium, particularly during care transitions.</p> <p>Strong uptake has been achieved. As at 31 December 2025, over 5,150 physical copies have been distributed and 6,300 digital downloads have occurred.</p> <p>Over 40 education and awareness activities have been undertaken, reaching more than 2500 people.</p> <p>Implementation insights revealed that successful uptake depends on proactive completion of the Julian’s Key tool in the community, meaning that consumer and care provider awareness and education activities are important. Clinical awareness and engagement are also critical to successful implementation.</p>